BLACKBUTT DOCTORS SURGERY
Quality healthcare made simple

OUR TOWN DOCTORS SURGERY
Quality healthcare made simple

Third Party Consent for Patients of Blackbutt Doctors and Our Town Doctors Surgeries

I (Name):___________________ Date of Birth: _______________________

of (Address):____

Hereby give permission for (Name): ______________________________________

from (address) ____

(Phone): ________________________ Date of Birth: ________________________

to act on my behalf for the following (Tick or Cross relevant Boxes below):

☐ Making and/or cancelling Appointments

☐ Take calls

☐ Receive results

☐ Make and confirm appointments

☐ Access and Request copies of my file

☐ Collect requested letters, requests for pathology and radiology forms etc

☐ Make or receive any other enquiries or correspondence from any Doctor, Nurse or Administrative staff member at Blackbutt Doctors and Our Town Doctors Surgeries.

If I choose to change this I will notify the surgery in writing and I understand that until I receive written confirmation from the surgery that this third party consent will still be in effect.

Third Party Representative Signature: ____

Patient Name: ______________________________ Date: _______________

Signed: ____________________________________